MARKET REFORMS (ACA & HIPAA) NON-GRANDFATHERED PLAN PROVISIONS

Self-Funded, Non-Federal Governmental Group Health Plans / Compliance Checklist

Note: This chart is a summary of certain provisions applicable to non-grandfathered, **self-funded, non-Federal governmental group** health plans, and is not an exhaustive list of all legal requirements.

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
45 C.F.R. § 146.180 **Effective Date:** Plan years beginning on or after September 23, 2010.	Sponsors of self-funded, non-Federal, governmental plans may elect to exempt those plans ("opt out") from the following provisions of title XXVII of the Public Health Service (PHS) Act: 1. Standards relating to benefits for newborns and mothers (Newborns and Mothers Health Protection Act of 1996); 2. Parity in the application of certain limits to mental health and substance use disorder benefits (Mental Health Parity and Addiction Equity Act of 2008); 3. Required coverage for reconstructive surgery following mastectomies (Women's Health and Cancer Rights Act of 1998); 4. Coverage of dependent students on a medically necessary leave of absence Michelle's Law, 2008. If a self-funded, non-Federal, governmental plan sponsor correctly complies with the requirements for electing and maintaining an opt-out, it will **not** be considered out of compliance with the provisions from which it is exempted (please see	**FYI only:** Prior to the enactment of the ACA, sponsors of self-funded, non-Federal governmental plans could opt out of seven provisions of the PHS Act. In addition to the four provisions enumerated in the summary section, sponsors of these plans could opt out of: 1. Limitations on pre-existing condition exclusion periods; 2. Requirements for special enrollment periods; 3. Prohibitions against discriminating against individual participants and beneficiaries based on health status. The regulation (45 CFR §146.180) was updated on March 21, 2014 to clarify that these plans may no longer opt out of these provisions. If a plan document includes an exemption from all seven PHS Act provisions, it is out of compliance with the regulation. **Notice Requirement:**	CCIIO webpage: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/non_federal_governmental_plans_04072011.html Regulations and Guidance: https://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf https://www.cms.gov/CCIIO/Resources/Files/Downloads/opt_out_memo.pdf https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/hipaa-exemption-guidance-7212014.pdf https://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html	☐ YES ☐ NO Opted out of: ☐ NMHPA ☐ MHPAEA ☐ WHCRA ☐ Michelle's

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	"Additional Public Health Service Act Protections" section for more detail).	Plan administrators must annually provide enrollees notice that they opted out of the PHS Act provisions. Notice language is provided in the regulation, and should be provided to enrollees in the plan document or in a separate mailing. **Electronic Opt-Outs:** All opt out elections must be made electronically via the HIOS NonFed module as described in the updated regulation, and in the guidance (see link to the right).		
Preexisting Condition Exclusions: PHS Act § 2704 (42 U.S.C. § 300gg-3)				
45 C.F.R. § 147.108 **Effective Date:** For individuals under 19: Plan years beginning on or after September 23, 2010. For all individuals: Plan years beginning on or after January 1, 2014.	A self-funded, non-Federal, governmental plan may not impose any preexisting condition exclusion (as defined in 45 C.F.R. § 144.103). Plans may not apply pre-existing condition exclusions: • To enrollees under 19, beginning 9/23/2010; • To all enrollees beginning 01/01/2014.	Note: this includes initially denying coverage of a child under age 19 due to a pre-existing condition.	Regulations and Guidance: Final Rule: https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=23983	☐ YES ☐ NO
Discrimination Based on Health Status: PHS Act § 2705 (42 U.S.C. § 300gg-4)				
45 C.F.R. § 146.121	A self-funded, non-Federal, governmental plan may not establish any rule for eligibility (including	The regulation further defines "evidence of insurability" as conditions arising from acts	Regulations and Guidance:	☐ YES ☐ NO

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Effective Date: Plan years beginning on or after January 1, 2014. Note: Nondiscrimination requirements under HIPAA applied *prior to January 1, 2014*.	continued eligibility) of any individual to enroll for benefits under the terms of the plan or charge more in premiums or contributions for coverage because of any of the following health factors: • health status; • medical condition, including both physical and mental illnesses (as defined in 45 C.F.R. § 144.103); • claims experience; • receipt of health care; • medical history; • genetic information (as defined in 45 C.F.R. § 146.122(a)); • evidence of insurability; or • disability The Affordable Care Act amended provisions regarding wellness programs (*see below*).	of domestic violence and participation in certain activities. See 45 C.F.R. § 146.121(a)(2). Plans may not establish any rule for eligibility based on a health factor – these include (but are not limited to) rules relating to: • enrollment; • effective date of coverage; • waiting periods; • late and special enrollment; • eligibility for benefit packages; • benefits; • continued eligibility; and • terminating coverage under the plan More favorable treatment for individuals with adverse health factors is permitted. Examples: 45 C.F.R. § 146.121 contains examples.	45 C.F.R. § 146.121 - http://www.gpo.gov/fdsys/pkg/FR-2006-12-13/pdf/06-9557.pdf http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28361.htm Fact Sheets and FAQs: FAQ – nondiscrimination Q12 - Q15 http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html http://www.cms.gov/CCIIO/Resources/Files/Downloads/market-rules-nprm-technical-summary-11-20-2012.pdf FAQ from Department of Labor - http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html	
Genetic Information and Nondiscrimination Act (GINA) 45 C.F.R. § 146.121(a)(1)(vi), § 146.122	GINA amends the Public Health Service Act to generally prohibit a self-funded, non-Federal governmental group health plan from: • Denying coverage based on family history or genetic information; • Setting or increasing the group premium or contribution amounts based on family history or genetic information;	45 C.F.R. § 146.122 includes definitions and examples.	Statute and Regulations– http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/genetic/ginaifr.pdf DOL GINA FAQs: http://www.dol.gov/ebsa/faqs/faq-GINA.html	☐ YES ☐ NO

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Effective Date: Plan years beginning on or after December 7, 2009 for group coverage.	• Requesting or requiring an individual or family member to undergo a genetic test; and • Requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.			
Wellness Programs Provision 45 C.F.R. § 146.121(f) **Effective Date**: Plan years beginning on or after January 1, 2014.	As stated in the statutory provision, § 2705(j)(3): effective for plan years beginning on or after January 1, 2014, increases the maximum reward to 30 percent and authorizes the Departments to increase the maximum reward to as much as 50 percent if the Departments determine that such an increase is appropriate.	An exception to the general rule against discrimination is provided for certain wellness programs that discriminate in benefits and/or premiums based on a health factor. The regulations generally divide wellness programs into two categories: • participatory wellness programs; and • health-contingent wellness programs	Regulations and Guidance: Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 77 Fed. Reg. 70620 (proposed Nov. 26, 2012) (to be codified at 45 C.F.R. § 146.121, § 147.110): https://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28361.pdf	☐ YES ☐ NO
Non-Discrimination in Health Care: PHS Act § 2706 (42 U.S.C. § 300gg-5)				
Effective Date: Plan years beginning on or after January 1, 2014.	A self-funded, non-Federal, governmental group health plan "shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law."	Section 2706(a) is self-implementing, and regulations are not expected in the near future (see FAQ link). Plans are expected to use a good faith, reasonable interpretation of the law.	Statute: 42 U.S.C. § 300gg-5 http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXXV-partA-subpart1-sec300gg-5.htm Fact Sheets and FAQs: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-	☐ YES ☐ NO

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Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
			FAQs/aca_implementation_faqs15.html (see Q2)	
Essential Health Benefits (EHB)- Out of Pocket Maximum Limitations: PHS Act § 2707(b) (42 U.S.C. § 300gg-6); ACA § 1302(c)				
45 C.F.R. §156.130. **Effective Date**: Plan years beginning on or after January 1, 2014.	A self-funded, non-Federal, governmental group health plan must comply with the annual limitation on out of pocket maximums (MOOPs) provided for in section 1302(c)(1) of the ACA. Each policy year after 2014, the MOOP is increased by the premium adjustment percentage (described under ACA section 1302(c)(4)). For plan years **beginning in 2016**, the maximum out of pocket (MOOP) for self-only coverage is: $6,850; MOOP for coverage other than self-only coverage is: $13,700. For plan years **beginning in 2017**, the MOOP for self-only coverage is: $7,150; MOOP for coverage other than self-only coverage will be: $14,300.	See portion of separate checklist for handling EHB reviews concerning cost-sharing and maximum out of pocket (MOOP) limits. Cost sharing limitations in section 1302(c)(1) are applied only to EHBs.	CCIIO webpage: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html Regulations and Guidance: Final Rule July 20, 2012: EHB Data Collection http://www.gpo.gov/fdsys/pkg/FR-2012-07-20/pdf/2012-17831.pdf Final Rule, Notice of Benefit and Payment Parameters, 2015 (e.g., "2015 Payment Notice"): https://www.federalregister.gov/articles/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015 Fact Sheets and FAQs: FAQ set 12 http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html	☐ YES ☐ NO

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			FAQ set 18 http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Reference_Pricing_FAQ_101014.pdf	
Prohibition on Excessive Waiting Periods: PHS Act s 2708 (42 U.S.C. s 300gg-7)				
45 C.F.R. § 147.116 **Effective Date:** Plan years beginning on or after January 1, 2014.	A self-funded, non-Federal, governmental group health plan shall not apply any waiting period that exceeds 90 days ("Waiting period" is defined in PHS Act section 2704(b)(4) and interpreted in 45 C.F.R. § 147.116).	A waiting period is the period that must pass with respect to an individual who is otherwise eligible to be covered for benefits under the terms of the plan before coverage for that individual can be effective. Restrictions on benefit-specific waiting periods do not apply to self-funded, non-Federal, governmental group health plans.	Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03809.pdf	☐ YES ☐ NO
Clinical Trials: PHS Act § 2709 (42 U.S.C. § 300gg-8)				
Effective Date: Plan years beginning on or after January 1, 2014.	A self-funded, non-Federal, governmental group health plan that covers a "qualified individual" (as defined under PHS Act section 2709(b)) may not do any of the following: • Deny the individual from participating in a specified approved clinical trial;	Note requirements of a "qualified individual." PHS Act § 2709(b). Note definition of "routine patient costs" and the exclusions. PHS Act § 2709(a)(2).	Statute: http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapXXV-partA-subpart1-sec300gg-8.pdf	☐ YES ☐ NO

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
	• Deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection to the individual's participation in the trial (to the extent provided within the plan's network, if applicable); or • Discriminate against the individual on the basis of his/her participation in the trial.	Note provisions on use of in-network providers and out-of-network providers.	FAQ set 15: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html	
Lifetime Limits: PHS Act § 2711 (42 U.S.C. § 300gg-11)				
45 C.F.R. § 147.126 **Effective Date:** Plan years beginning on or after September 23, 2010.	Lifetime limits on the dollar value of EHBs are prohibited (see non-grandfathered ACA HIPAA checklist for list of EHB categories under 2707).	Self-funded, non-Federal, governmental plans are not required to provide EHBs. However, if they do provide such benefits, they are prohibited from placing lifetime dollar limits on them. Specific covered services that are not EHBs are not subject to the prohibition on lifetime limits. If the limit is not a dollar limit (i.e., a lifetime visit limit), this prohibition will not be triggered unless the visit limit incorporates a specific dollar amount per visit.	Regulation: Final Rule: https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits 45 C.F.R. § 147.126 - http://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/xml/CFR-2010-title45-vol1-sec147-126.xml CCIIO webpage: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Annual-Limits.html	☐ YES ☐ NO

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Annual Limits: PHS Act § 2711 (42 U.S.C. § 300gg-11)				
45 C.F.R. § 147.126 **Effective Date:** Plan years beginning on or after September 23, 2010.	Restricted annual limits on the dollar value of EHBs were permitted for plan years beginning before 1/1/2014. Annual limits on the dollar value of EHBs are prohibited as of plan years beginning in 2014.	As with lifetime limits, self-funded, non-Federal governmental plans are not required to provide EHBs. However, if these benefits are provided, plans may not place annual limits on the dollar value of the benefit. Plans may impose annual limits on specific covered benefits that are not EHBs. If the limit is not a dollar limit (i.e., an annual visit limit), the annual limit prohibition would not be triggered, unless the visit limit incorporates a specific dollar amount per visit.	Regulation: 45 C.F.R. § 147.126 - http://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/xml/CFR-2010-title45-vol1-sec147-126.xml CCIIO webpage: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Annual-Limits.html	☐ YES ☐ NO
Rescissions: PHS Act § 2712 (42 U.S.C. § 300gg-12)				
45 C.F.R. § 147.128 **Effective Date:** Plan years beginning on or after September 23, 2010.	Coverage may only be rescinded in the event of an act or omission that constitutes fraud or intentional misrepresentation of a material fact by the enrollee. A discontinuation or cancellation with retroactive effect due to non-payment of premiums is not a rescission. A self-funded, non-Federal, governmental plan is required to provide thirty (30) days' advance written notice prior to rescinding coverage. The	An inadvertent misstatement of fact does not constitute fraud (e.g., forgetting to mention psychologist visits when completing a medical history on enrollment).	Regulations and Guidance: Final Rule: https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits Fact Sheets and FAQs: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html	☐ YES ☐ NO

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
	enrollee may appeal this decision under 45 C.F.R. § 147.136 (Appeals provision).			
Preventive Health Services: PHS Act § 2713 (42 U.S.C. § 300gg-13)				
45 C.F.R. § 147.130 **Effective Date:** Plan years beginning on or after September 23, 2010.	Coverage of certain recommended preventive health services without imposing cost-sharing requirements on enrollees. Note that although self-funded, non-Federal, governmental plans are not required to cover EHBs, they are required to cover preventive health services under this separate provision of the ACA.	Self-funded, non-Federal, governmental plans must provide coverage for all of the following items and services, and may not impose any cost sharing requirements with respect to those services: • Current, United States Preventive Services Task Force (USPSTF) A- or B-rated items or services with respect to the individual involved; • Immunizations for routine use in children, adolescents, and adults with recommendation from Advisory Committee on Immunization Practices (ACIP) of the CDC. • For infants, children, and adolescents, evidence-informed preventive care screenings supported by HRSA guidelines; • For women, evidence-informed preventive care screenings recommended by HRSA and not already included in recommendations by the USPSTF; and The plan generally is not required to cover recommended preventive services delivered	CCIIO webpage: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Prevention.html Regulations and Guidance: http://cciio.cms.gov/resources/regulations/index.html#prevention Fact Sheets on the CCIIO website: http://cciio.cms.gov/resources/factsheets/index.html#prevention FAQs about Preventive Care Services: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html (see Q8 - reasonable medical management) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html (see Q1 - value-based insurance design)	☐ YES ☐ NO

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		by out-of-network providers, and may impose cost-sharing requirements for such providers. NOTE: While nothing in the regulations generally requires a plan that has a network of providers to provide benefits for preventive services provided out-of-network, this provision is premised on enrollees being able to access the required preventive services from in-network providers. Thus, if a plan does not have in its network a provider who can provide the particular service, then the plan must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service. See ACA FAQ 12 Q3. See 45 C.F.R. § 147.130(a)(2) for when an office visit is billed separately from the preventive service provided. USPSTF-recommended OTC drugs must be covered without cost-sharing if prescribed by a doctor. See ACA FAQ 12 Q4. The plan may not impose cost-sharing for polyp removal performed during a screening colonoscopy. However, a plan may impose cost-sharing for a treatment that is not a	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html (see Q3 – Q20 – out-of-network, specifics about USPSTF, ACIP, HRSA guidelines) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html (see Q1 - USPSTF breast cancer recommendation) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html (see Q5 - tobacco cessation interventions) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-aca20.pdf (notice requirements for cessation of contraceptive services coverage) https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf	

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		recommended preventive service, even if the treatment results from a recommended preventive service. See ACA FAQ 12, Q5, FAQ 26, Q7. If the applicable guidelines/recommendations for a preventive service do not identify the frequency, method, treatment, or setting for which such service should be available without cost-sharing requirements, a plan may rely on reasonable medical management techniques and relevant evidence to make the determinations.	USPSTF A- and B-rated items and services: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ Advisory Committee on Immunization Practices Recommendations: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html Health Resources and Services Administration Recommendations (HRSA): http://www.hrsa.gov/womensguidelines/	
Notice of Material Modification 45 C.F.R. § 147.200(b)(2) **Effective Date:** Plan years beginning on or after September 23, 2010.	The plan must give enrollees 60 days' advance notice before any material modification in coverage, such as no longer covering a preventive health item or service.	If an item or service ceases to be recommended by the USPSTF or HRSA or the CDC, the self-funded, non-Federal governmental plan is obligated to cover it under this provision through the end of the plan year during which it was recommended.	Regulation: http://www.ecfr.gov/cgi-bin/text-idx?SID=2caa93a1871f6c06e235badfa673ea4c&node=se45.1.147_1130&rgn=div8 See also 45 C.F.R. § 147.200(b): http://www.ecfr.gov/cgi-bin/text-idx?SID=feded91ad359024a86ab4713133e7228&node=se45.1.147_1200&rgn=div8	☐ YES ☐ NO

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Dependent Coverage until 26 Years of Age: PHS Act § 2714 (42 U.S.C. § 300gg-14)				
45 C.F.R. § 147.120 **Effective Date:** Plan years beginning on or after September 23, 2010.	Extension of dependent coverage until 26 years of age Self-funded, non-Federal, governmental plans that provide for dependent coverage for children must continue to make such coverage available until age 26.	The plan need not extend coverage to such dependents' spouses or children. Dependent eligibility can only be defined in terms of the relationship between the child and the subscriber. Requirements for eligibility cannot include: • Financial dependency; • Residency (including living or working in the plan service area) • Eligibility for other coverage; • Student status; • Employment; and • Marital status Terms of dependent coverage cannot vary based on age for children under age 26. For example: plans cannot impose a premium surcharge for dependents over 18. Note that this does not prohibit plans from imposing age rating.	CCIIO webpage: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Coverage-for-Young-Adults.html Regulations and Guidance: Final Rule: https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits Fact Sheets and FAQs: http://www.cms.gov/cciio/resources/Regulations-and-Guidance/index.html#Coverage for Young Adults http://www.cms.gov/CCIIO/Resources/Files/adult_child_fact_sheet.html http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html	☐ YES ☐ NO

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
			http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html (see Q14) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html# (see Q5)	
Summary of Benefits and Coverage (SBC): PHS Act § 2715 (42 U.S.C. § 300gg-15)				
45 C.F.R. § 147.200 **Effective Date:** Plan years beginning on or after September 23, 2012.	Uniform explanation of coverage documents and standardized definitions.	Please see separate checklist for handling SBC reviews.	CCIIO webpage: http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html	☐ YES ☐ NO
Appeals: PHS Act § 2719 (42 U.S.C. § 300gg-19)				
45 C.F.R. § 147.136 **Effective Date:** Plan years beginning on or after September 23, 2010.	Internal claims appeals and external review process required of self-funded, non-Federal governmental plans. The appeals team will generally evaluate all complaints concerning appeals before beginning a collaboration with the NFGP team. The appeals team retains primary responsibility for consumer-facing aspects of the complaint. The NFGP team	Plan must provide a description of available claims procedures, internal appeals and external review processes, including information regarding how to initiate an appeal as part of the Summary Plan Description (SPD) (or policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to enrollees).	Regulations and Guidance: Final Rule: https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits	☐ YES ☐ NO

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
	takes primary responsibility for any plan, Third Party Administrator (TPA), and compliance or Civil Monetary Penalty (CMP) aspects of the complaint.	The plan must also describe the exceptions available to exhausting the internal claims and appeals process ("deemed exhaustion") such as: • Plan waives internal appeal; • Urgent care situations where simultaneous expedited internal and external review may occur; or • Failure to comply with all requirements of internal appeals process except in cases where the violation was: o De minimis; o Non-prejudicial; o Attributable to good cause/matters beyond plan's control; o In context of ongoing good-faith exchange of information; and o Not reflective of a practice of non-compliance. See link to the right to determine if the state or federal process applies to a NFGP in a given state. For example; MO & OK meet the strict federal standards so MO/OK plans follow state's external review process; TX & WY meet the less strict federal similar standards so plans follow TX/WY external review process (until January 1, 2017); AL	*In particular see*: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html Fact Sheets and FAQs: http://www.cms.gov/cciio/Resources/Fact-Sheets-and-FAQs/index.html#External Appeals http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html (See Set 1, Q&As 7-14.) See June 2011 Technical Release 2011-02 for explanation of "similar" standards. Also contains Model External Review Notice: http://www.cms.gov/CCIIO/Resources/Files/Downloads/appeals_srg_update.pdf See state vs. federal process determination chart below: http://www.cms.gov/cciio/resources/files/external_appeals.html Technical Release: Extension of federal-similar External Review process transition period through 12/31/2016 (see Appeals Final Rule)	

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
		does not have an effective process, so the plan may choose one of the federal processes: either the HHS- administered process or an independent review organization (IRO) reviews external appeals and plan policy forms should note this.		
45 C.F.R.§ 147.136(e) **Effective Date**: Plan years beginning on or after September 23, 2010.	Notice of right to appeal; self-funded, non-Federal, governmental plans must provide notice to individuals in a culturally and linguistically appropriate manner.	The plan must provide the written notice of the right to appeal in a culturally and linguistically appropriate manner and must also provide oral language services, including answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language, using culturally & linguistically appropriate services (CLAS). The plan must also provide, upon request, a notice in any applicable non-English language. Additionally, the plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan. Applicable non-English language is determined by a threshold percentage of	2014 County CLAS data/ACS: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data_12-05-14_clean_508.pdf Note that data is updated annually. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html (Q13)	☐ YES ☐ NO

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		10% of the population or more who are literate only in the same non-English language based on the American Community Survey (ACS). Example: 39% of the population of Santa Cruz county, AZ are literate only in Spanish, so plans serving that area must provide notices in Spanish compliant with CLAS guidelines.		
45 C.F.R. § 147.136 **Effective Date**: Plan years beginning on or after September 23, 2010.	Notice of appeal determination; form and content of determination notice	The self-funded, non-Federal, governmental plan must provide a written or electronic notification of a plan's benefit determination. Content of notification must include: • Enough information to identify the claim involved; • Reason(s) for the determination; • Reference to specific plan provision(s) or standard used to deny the claim; and • A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the corresponding treatment code and its meaning. Plans must provide effective written notice to claimants of their rights in connection with an internal claim appeal and external	Regulations and Guidance: http://www.cms.gov/CCIIO/Resources/Files/Downloads/appeals_srg_update.pdf (model Internal Appeals and External Review notice determinations on last few pages)	☐ YES ☐ NO

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
		review for an adverse benefit determination (ABD) or final internal ABD. Plans must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes. Plans must provide the exceptions available to exhausting the internal claims appeals process (see exceptions above). Claimant may initiate external review once internal claims appeals process is exhausted or deemed exhausted if the plan fails to follow all of the specific state or federal regulatory requirements. A plan must follow state external appeals requirements if they are effective, and if not, apply federal external review requirements as explained in regulation. Claimant must be given four months from receipt of ABD or final internal ABD to file request for external review. An Independent Review Organization (IRO) must be assigned either randomly or by rotation. ABDs based on eligibility under the		

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		terms of a group health plan are not subject to the Federal external review process.		
Patient Protections: PHS Act § 2719A (42 U.S.C. § 300gg-19a)				
45 C.F.R. § 147.138(a)(1) **Effective Date**: Plan years beginning on or after September 23, 2010.	Choice of health care professional	If the self-funded, non-Federal, governmental group health plan requires or allows for designation of a primary care provider (PCP), then the plan shall permit each individual to designate any participating primary care provider who is available to accept such individual. If a PCP is mandated and the individual fails to designate a PCP, the plan may designate one until the individual does so. Nothing in the patient protections final rule prohibits network plans from applying reasonable and appropriate geographic limitations on an enrollee's choice of primary care provider.	Regulations and Guidance: Final Rule: https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits Federal Register | Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Patients-Bill-of-Rights.html Fact Sheets and FAQs: http://www.cms.gov/CCIIO/Resources/Files/Downloads/protecting_your_choice_of_health_care_providers_04072011.pdf	☐ YES ☐ NO

MARKET REFORMS (ACA & HIPAA) NON-GRANDFATHERED PLAN PROVISIONS

Self-Funded, Non-Federal Governmental Group Health Plans / Compliance Checklist

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
45 C.F.R. § 147.138(a)(2) **Effective Date**: Plan years beginning on or after September 23, 2010.	Choice of pediatrician as primary care provider	If the plan requires or allows for designation of a PCP for a child, a person shall be permitted to designate a physician who specializes in pediatrics (allopathic or osteopathic) as a child's primary care provider, if such provider participates in the network of the plan and is available to accept the child.	See above	☐ YES ☐ NO
45 C.F.R. § 147.138(a)(3) **Effective**: Plan years beginning on or after September 23, 2010.	Direct access to obstetrical and gynecological care	A plan that provides coverage for OB/GYN care and requires the designation of a PCP must comply with the following: • may not require prior authorization or a referral for a female patient to see a participating provider specializing in OB/GYN care; • Must permit OB/GYN providers to directly refer for or order OB/GYN-related items and services without approval of another provider, including a PCP. Note: If no coverage for OB/GYN care is provided, the plan does not have to comply with this provision.	See above	☐ YES ☐ NO
45 C.F.R. § 147.138(a)(4) **Effective Date**:	Notice requirement	Notices regarding the above requirements must be provided to each participant of a group health plan or primary subscriber of a		☐ YES ☐ NO

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
Plan or policy years beginning on or after September 23, 2010.		policy and can be in the Summary Plan Description (SPD). Notice must be included whenever a new SPD/policy/certificate is issued.		
45 C.F.R. § 147.138(b) **Effective**: Plan years beginning on or after September 23, 2010.	Coverage of emergency services	If emergency services benefits in a hospital are covered or provided for by the self-funded, non-Federal, governmental plan, those services shall be covered: • Without the need for a prior authorization determination; • Without regard to whether the health care provider furnishing such services is a participating provider with respect to such services; and • If such services are provided by an out of network (OON) provider, without imposing administrative requirements or coverage limitations that are more restrictive than or cost sharing requirements that exceed those that would apply if such services were provided in-network. See regulation for definition of "emergency services." Cost-Sharing and Deductible:	Regulations and Guidance: Final Rule: https://www.federalregister.gov/articles/2015/11/18/2015-29294/final-rules-for-grandfathered-plans-preexisting-condition-exclusions-lifetime-and-annual-limits Fact Sheets and FAQs: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html#Out-Of-Network Emergency Services (FAQ Set 1, Q 15) Summary of EMTALA (Baylor Univ. Med Center Proceedings/Journal): http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/	☐ YES ☐ NO

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
		See regulation and below for special rules concerning out of network cost-sharing. Members served by OON providers can be balance billed for amounts charged in excess of the amount allowed for in-network cost sharing. Plans must cover Emergency Services, excluding any in-network cost-sharing, at the greater of the following: (1) the median rate the plan would pay an in-network provider (the provider may balance-bill the remainder), (2) the Medicare Part A or B fee schedule, or (3) the rate paid by the plan for any other out-of-network (OON) services (e.g., U&C, reasonable amount, discount offered by secondary network). Provider can hold member responsible for any remaining balance billed by the OON provider. The plan can apply OON deductible only if one applies to other OON benefits generally. If there is a MOOP for other OON benefits, it MUST be applied to the ER services. *New special rules regarding OON minimum payment standards (Final Rule)*-- Minimum payment standards do not apply where state law **prohibits** balance billing or where a group health plan is contractually		

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		responsible for excess charges (over what plan provides in benefits) billed by OON provider. In such cases, a plan may **not** impose any copayment or coinsurance requirement for OON emergency services higher than cost-sharing for in-network emergency services. Additionally, a group health plan must provide members adequate and prompt notice of their lack of financial responsibility to avoid inadvertent payment by the member.		
Additional Public Health Service Act Protections				
Newborns and Mothers Health Protection Act (1996) PHS Act § 2725 PHS Act § 2751 42 USC § 300gg-25 42 USC 300gg-51 45 CFR § 146.130 45 CFR § 148.170	NMHPA: Standards relating to benefits for newborns and mothers		CCIIO webpage: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/NMHPA.html Fact Sheets & FAQs: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html	Opted Out? ☐ YES ☐ NO If NO, is contract compliant? ☐ YES ☐ NO
Mental Health Parity and Addiction Equity Act (2008) PHS Act § 2726 42 USC § 300gg-26	MHPAEA: Parity in the application of certain limits to mental health and substance use disorder benefits. Non-Federal governmental health plans with 50 or fewer employees (100 or	Parity requirements must be met in the way MH/SUD and medical/surgical benefits are treated with respect to: • Annual and lifetime dollar limits; • Financial requirements;	Regulation & Guidance: http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf Fact Sheets & FAQs:	Opted Out? ☐ YES ☐ NO

MARKET REFORMS (ACA & HIPAA) NON-GRANDFATHERED PLAN PROVISIONS

Self-Funded, Non-Federal Governmental Group Health Plans / Compliance Checklist

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(cross-references 29 USC § 1185(a)) 45 CFR § 146.136	fewer in some states) are exempt from MHPAEA requirements. MHPAEA does not require a plan offer mental health or substance use disorder (MH/SUD) benefits; only that if it does offer such benefits, it comply with MHPAEA's parity provisions.	• Out of network benefits; and • Treatment limitations: o Quantitative, e.g.: visit limits, days of coverage; o Non-quantitative, e.g.: medical management standards, formulary design, or methods for determining reasonable and customary amounts). The law's requirements apply only to self-funded, non-Federal, governmental health plans that choose to include MH/SUD benefits in their benefit packages. Also, as indicated earlier, self-funded, non-Federal governmental plans can elect to opt out of MHPAEA.	https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html DOL Fact Sheet: http://www.dol.gov/ebsa/newsroom/fsmhpaea.html	If NO, is contract compliant? ☐ YES ☐ NO
Women's Health and Cancer Rights Act (1998) PHS Act § 2727 PHSA § 2752 42 USC § 300gg-52 (cross-references 29 USC § 1185(b)) 42 USC § 300gg-27	WHCRA: Required coverage for reconstructive surgery following mastectomies	WHCRA is a self-implementing statute, so no regulations have been drafted.	CCIIO webpage: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/WHCRA.html Fact Sheets & FAQs: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html	Opted Out? ☐ YES ☐ NO If NO, is contract compliant? ☐ YES ☐ NO
Michelle's Law (2008) PHS Act § 2728 PHS Act § 2753 42 USC § 300gg-28	Coverage of students on a medically necessary leave of absence.	Michelle's Law is applicable in the following limited example: a plan offers dependent coverage to individuals up to age 29, but conditions the coverage for those 27 years	No guidance on CCIIO website.	Opted Out? ☐ YES ☐ NO

Federal Law Citations	Summary of the Provision	Notes	Links to Guidance/FAQs/Resources	Contract Compliant?
42 USC § 300gg-54	Law is limited in applicability based on the application of other regulations that provide overlapping protections. See limited example in Notes section.	and older on having full-time student status. If such a student takes a medically necessary leave of absence, they are protected from loss of coverage.		If NO, is contract compliant? ☐ YES ☐ NO